PRESCRIPTION CLAIM FORM

For Prescriptions filled before 9/1/2007
OR
For Prescriptions filled without the PharmaCare Card

Please attach prescription receipts to this form and mail to:
Covenant Administrators, Inc.
P.O. Box 105738
Atlanta, GA 30348-5738

COVENANT ADMINISTRATORS, INC.

Employer Information		
Employer Name: **Toccoa Falls College**		Group No.: **287**
Location Name: **N/A**		
Employee Information		
Last Name:	First Name:	MI:
Last 4 digits of Social Security #: **XX-XX-**___________		Date of Birth - **Please indicate Year only: XX/XX/**__________
Home Address (Street No./Apt. No.):		
City, State, Zip Code:		
Claim Information (Please attach copy of receipt or physician's statement of services)		
Claim is for: Name:	Relationship:	Date of Birth - **Please indicate Year only: XX/XX/**__________
For Questions, Please call Covenant Administrators: 678-258-8230 Mailing Address: P.O. Box 105738, Atlanta, GA 30348-5738 Fax: 678-258-8299		

Attach Prescriptions here.